Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HECTOR YANES, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

Respondent Name

DALLAS ISD

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0545-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: **"**The initial billing in the amount of $650.00 for procedure code 99456W5WP was received on March 21, 2011. It was audited on March 23, 2011 and check # 098625 in the amount of $650.00 was issued on April 6, 2011. The last page of the medical records provided an impairment rating of the left extremity. The bill was submitted for a second time and was received on May 31, 2011. The bill included procedure code 99456W5WP for $650.00 and procedure code 99456 MI for $50.00 for for a total billed amount of $700.00. the bill was treated as a reconsideration in accordance with rule 133.250(d)(1). Since the bill did not include the same codes and billed amounts as the original bill, procedure code 99456 MI was denied. In addition, the last page of the medical records included with the second submission was changed to reflect a non-compensable body part not previously identified on the first submission. In summary, no allowance is due for 99455-MI. The second submission included an additional procedure code and charge different than the original submission."

Response Submitted by: Argus Services Corporation, 9101 LBJ Freeway, Suite 600, Dallas, Texas 75243-2055

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 08, 2011	99456-MI	$50.00	$50.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated June 16, 2011
   - 193A – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly. *Rule 133.250(d)(1) requires a recon to include same codes, DOS & dollar amounts as original bill. Before 05/02/06 rule 134.304(k)
   - 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s) / Procedure is included in the value of another service/procedure billed on the same date*

   Explanation of benefits dated July 21, 2011
   - 193A – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly. *Rule 133.250(d)(1) requires a recon to include same codes, DOS & dollar amounts as original bill. Before 05/02/06 rule 134.304(k)

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed on May 27th, 2011 an amount $50.00 for CPT code 99456-MI, representing multiple impairment ratings as an amended line item, separate from previously billed and reimbursed line items. Documentation supports that the requestor billed for compensable areas as well as compensable combined with additional non-compensable body areas. As multiple impairments were rendered, the MAR for CPT 99456-MI is $50.00 per 28 Texas Administrative Code §134.204 (j)(4)(B) which states:

   > When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

   While other CPT codes on same day may be considered duplicates of services already reviewed, this line item was separate and the documentation supports reimbursement.
2. Documentation supports that a request for reconsideration was made after the denial on first submission of this amended bill on June 16, 2011 and an EOB from July 21, 2011 was provided that showed it had been denied as a duplicate rather than being processed as a reconsideration. Therefore, the MAR for 99456-MI of $50.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the additional amount ordered is $50.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the additional amount of $50.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 29, 2012 Dat

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.